TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Susan Van de Water, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0604-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

Amount in Dispute: $1815.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Commissioner Order was for return to work exam and nothing more … The requestor billed $250.00 for this exam and Texas Mutual paid $250.00 for it. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2016	Designated Doctor Examination	$1815.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 provides the requirements for designated doctor examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 748 – Type of examination was not requested (refer to DWC 22 or DWC 32).
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. What are the services in dispute?
2. Is the insurance carrier's reason for denial of payment supported?

Findings

1. Susan Van de Water, M.D. is seeking reimbursement for a designated doctor examination which includes procedure codes 99456-W5-WP, representing maximum medical improvement and impairment rating; 99456-MI, representing multiple impairments; 99456-W6-RE, representing extent of injury; 99456-W8-RE, representing return to work; and 99080-73, representing a work status report. Dr. Van de Water is seeking $0.00 for procedure codes 99456-W8-RE and 99080-73. Therefore, these services will not be considered in this dispute. Dr. Van de Water is seeking $1,250.00 for procedure code 99456-W5-WP, $50.00 for procedure code 99456-MI, and $500.00 for procedure code 99456-W6-RE. These are the services considered in this dispute.
2. Texas Mutual Insurance Company (Texas Mutual) denied disputed services with claim adjustment reason code 748 – "TYPE OF EXAMINATION WAS NOT REQUESTED (REFER TO DWC 22 OR DWC 32)." Texas Labor Code §408.0041(a) provides that:

   > At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   > (1) the impairment caused by the compensable injury;
   > (2) the attainment of maximum medical improvement;
   > (3) the extent of the employee's compensable injury;
   > (4) whether the injured employee's disability is a direct result of the work-related injury;
   > (5) the ability of the employee to return to work; or
   > (6) issues similar to those described by Subdivisions (1)-(5).

   Review of the submitted documentation finds Form OA32A, *COMMISSIONER ORDER: APPROVAL OF REQUEST FOR DESIGNATED DOCTOR EXAMINATION.* This form orders an examination by Dr. Van de Water to determine the ability of the injured employee to return to work, for the purpose of Supplemental Income Benefits, on the date of service in question. No evidence was presented that the division ordered any other evaluations. Texas Mutual's denial for this reason, therefore, is supported. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	January 11, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.